NTSB National Transportation Safety Board

Reducing Risk

While

Improving Productivity:

Presentation to:

Colorado Springs Utilities

Name: Christopher A. Hart

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Key Lessons Learned

The Contrast

- Conventional Wisdom:

Improvements that reduce risk usually *also reduce productivity*

- Lesson Learned from Proactive Aviation Safety Information Programs:

Risk can be reduced in a way that also results in *immediate productivity improvements*

Process Plus Fuel Creates A Win-Win

System Think Process

Information From Front Lines

Improved *Safety*

- AND -

Improved *Productivity*
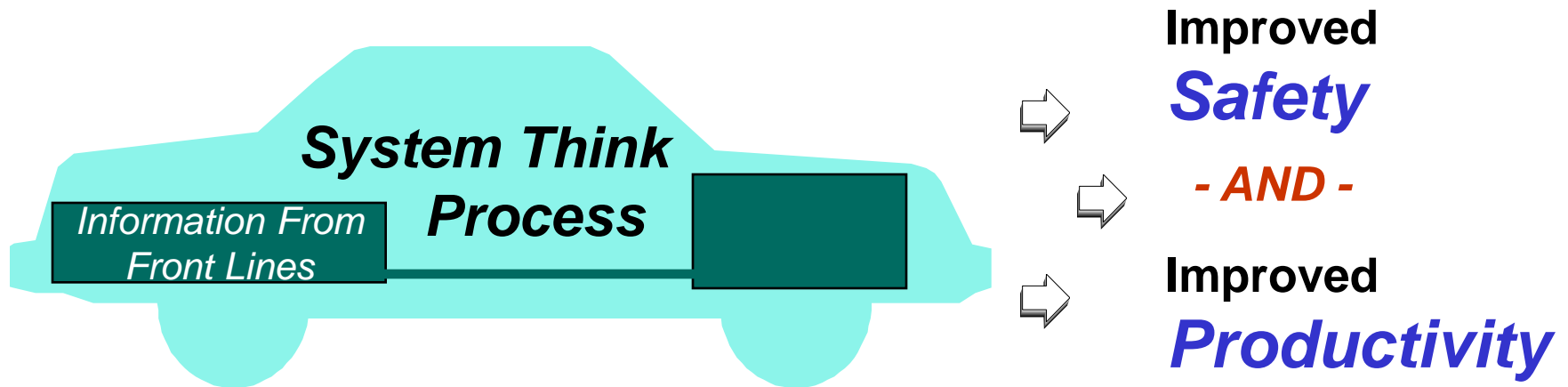
<u>Outline</u>

- The Context

- Importance of "System Think"

- Importance of Better Information

- Safety Benefits

- Productivity Benefits

- Aviation Successes and Failures

- Roles of Leadership and Regulator

NTSB Basics

- **Independent federal agency, investigate transportation accidents, all modes**
  - **Political independence**
  - **Functional independence**

- **Findings, recommendations based upon evidence rather than self-interest or politics**

- **Determine probable cause(s) and make recommendations to prevent recurrences**

- ***SINGLE FOCUS IS SAFETY***

- **Primary product: Safety recommendations**
  - **Favorable response > 80%**

The Context: Increasing Complexity

- **More System** *Interdependencies*
  - Large, complex, interactive system
  - Often tightly coupled
  - Hi-tech components
  - Continuous innovation
  - Ongoing evolution

- **Safety Issues Are More Likely to Involve** *Interactions Between Parts of the System*

AIRLINES

PILOTS

CONTROLLERS

The System

MECHANICS   MANUFACTURERS

INVESTIGATOR

REGULATOR
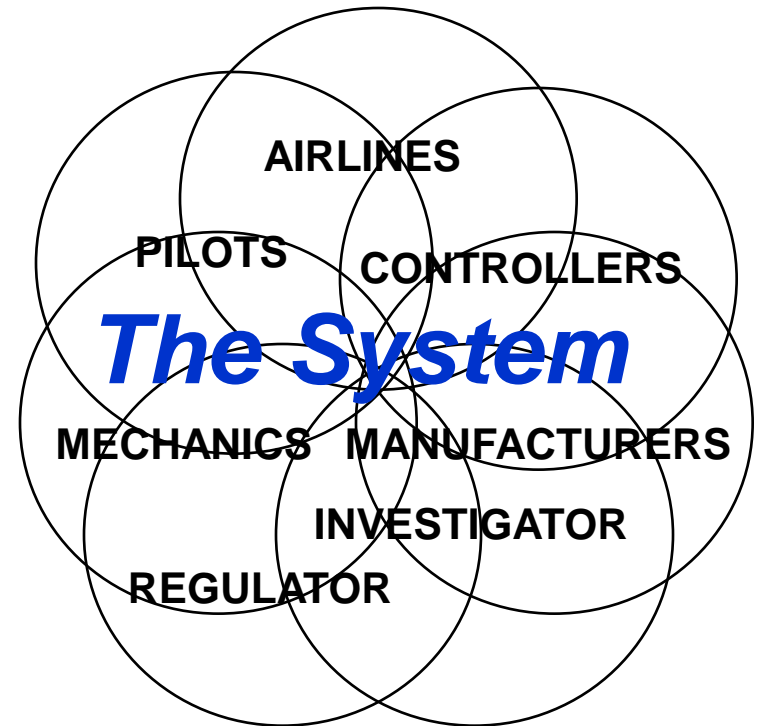
Effects of Increasing Complexity:

More "Human Error" Because

- System More Likely to be Error Prone

- Operators More Likely to Encounter Unanticipated Situations

- Operators More Likely to Encounter Situations in Which "By the Book" May Not Be Optimal ("workarounds")

The Result:

Front-Line Staff Who Are
- Highly Trained
- Competent
- Experienced,
-Trying to Do the Right Thing, and
- Proud of Doing It Well

. . . Yet They Still Commit

Inadvertent
Human Errors

The Solution – System Think

An awareness of how a change in one subsystem of a complex system may affect other subsystems within that system

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When Things Go Wrong

How It Is Now . . .

You are highly trained

and

If you did as trained, you would not make mistakes

so

You weren't careful enough

so

You should be PUNISHED!

How It Should Be . . .

You are human

and

Humans make mistakes

so

Let's *also* explore why the system allowed, or failed to accommodate, your mistake

and

Let's IMPROVE THE SYSTEM!

Fix the Person or the System?

Is the Person Clumsy?

Or Is the Problem . . .

The Step???

Enhance Understanding of Person/System Interactions By:

- Collecting,

- Analyzing, and

- Sharing

Information

Objectives:

Make the System

(a) Less Error Prone

and

(b) More Error Tolerant

# The Health Care Industry

To Err Is Human:

Building a Safer Health System

"The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system."
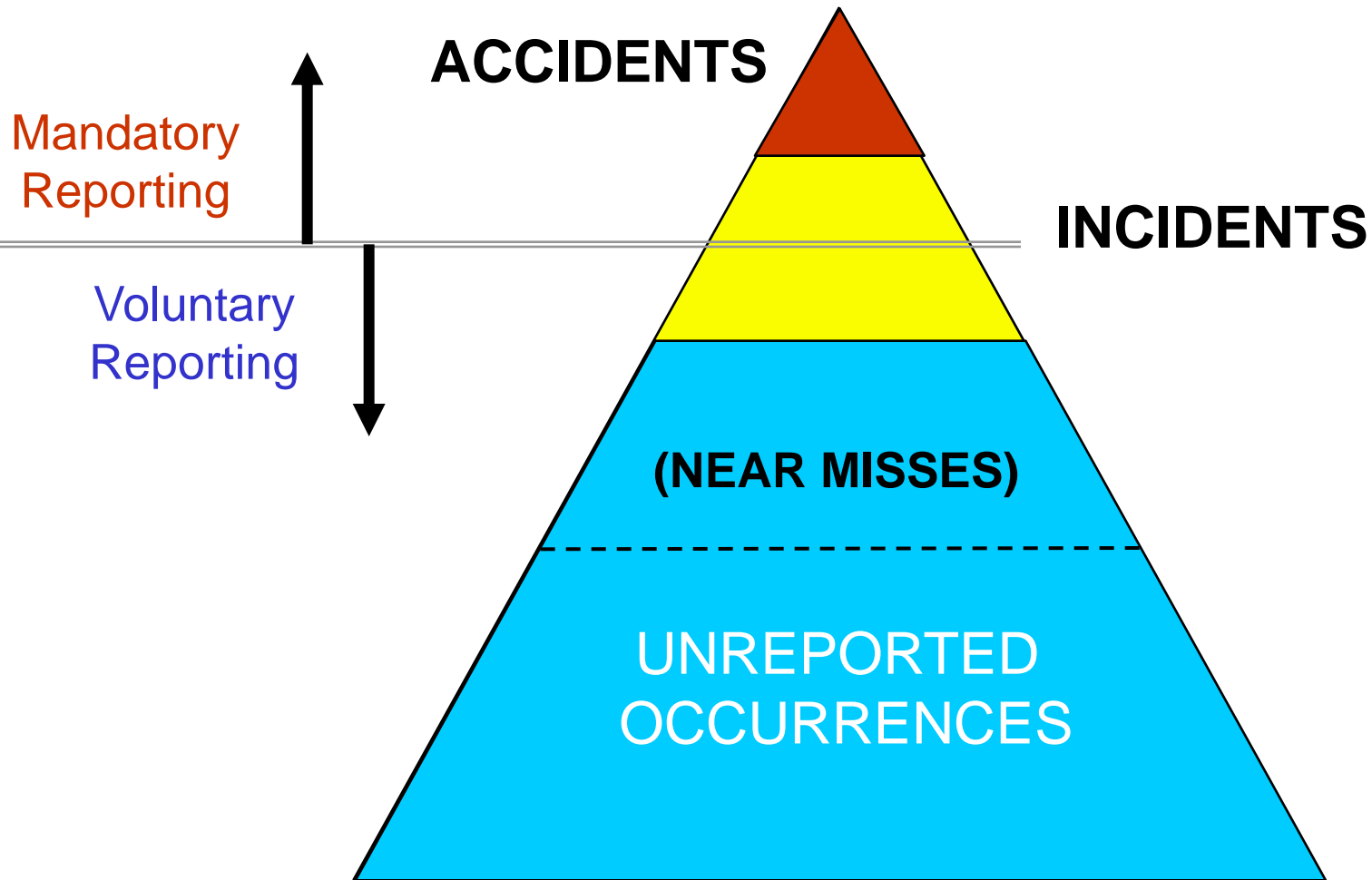
Institute of Medicine, Committee on Quality of Health Care in America, 1999

Current System Data Flow

Most Data Lost Forever

Currently Only a Minute Portion of Data is Collected and Analyzed
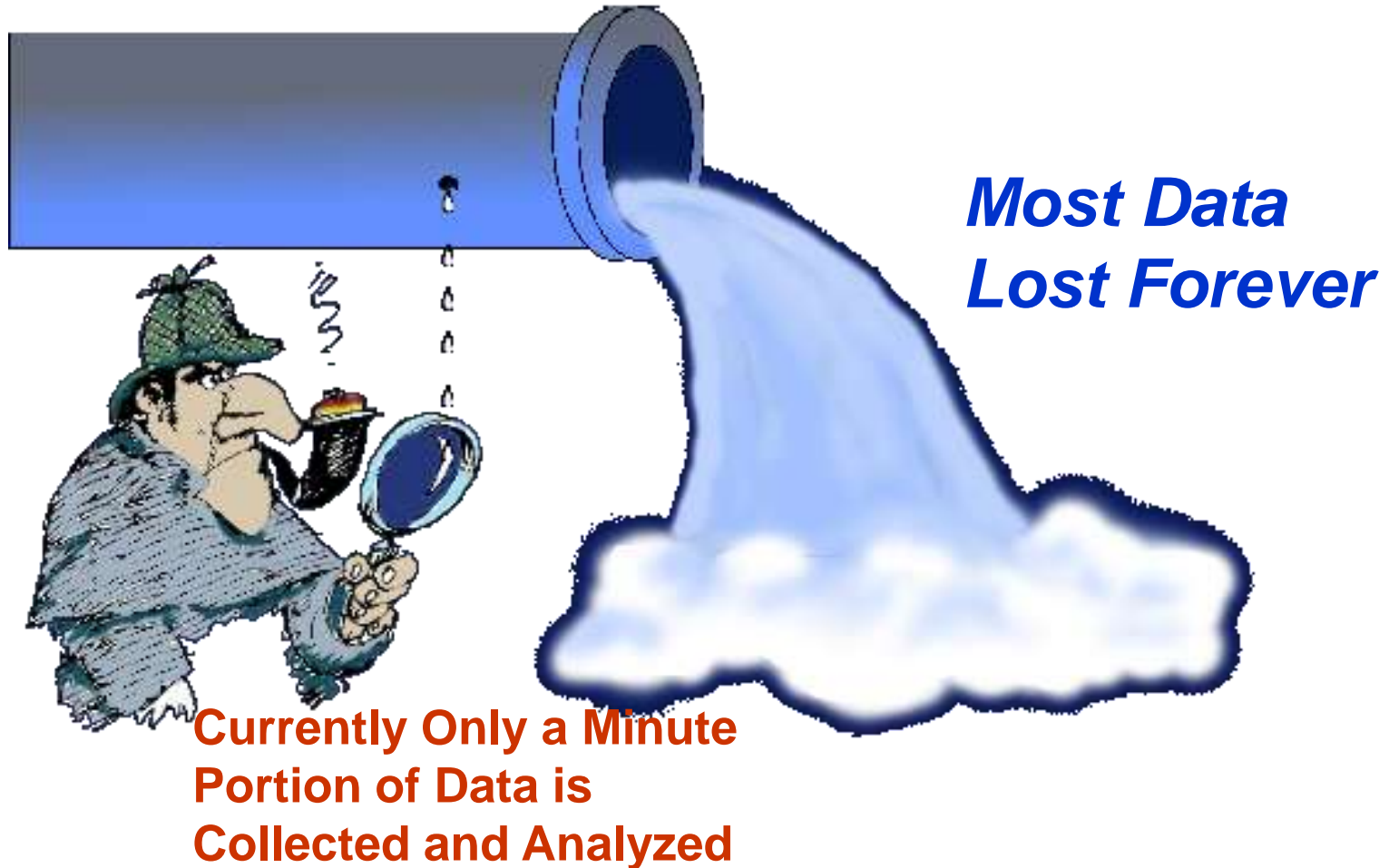
Heinrich Pyramid

Major Source of Information: Hands-On "Front-Line" Employees

"We Knew About That Problem"

(and we knew it might hurt someone sooner or later)

Legal Concerns That Discourage Collection, Analysis, and Sharing

- **Public Disclosure**

- **Job Sanctions and/or Enforcement**

- **Criminal Sanctions**

- **Civil Litigation**
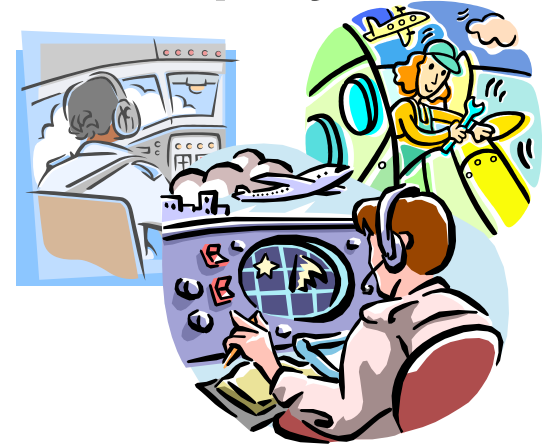
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Typical "Cultural" Barrier

CEO

Middle Management

Front-Line Employees

"Safety First"

"Production First"

"Please the Boss First…
THEN Consider Safety?"
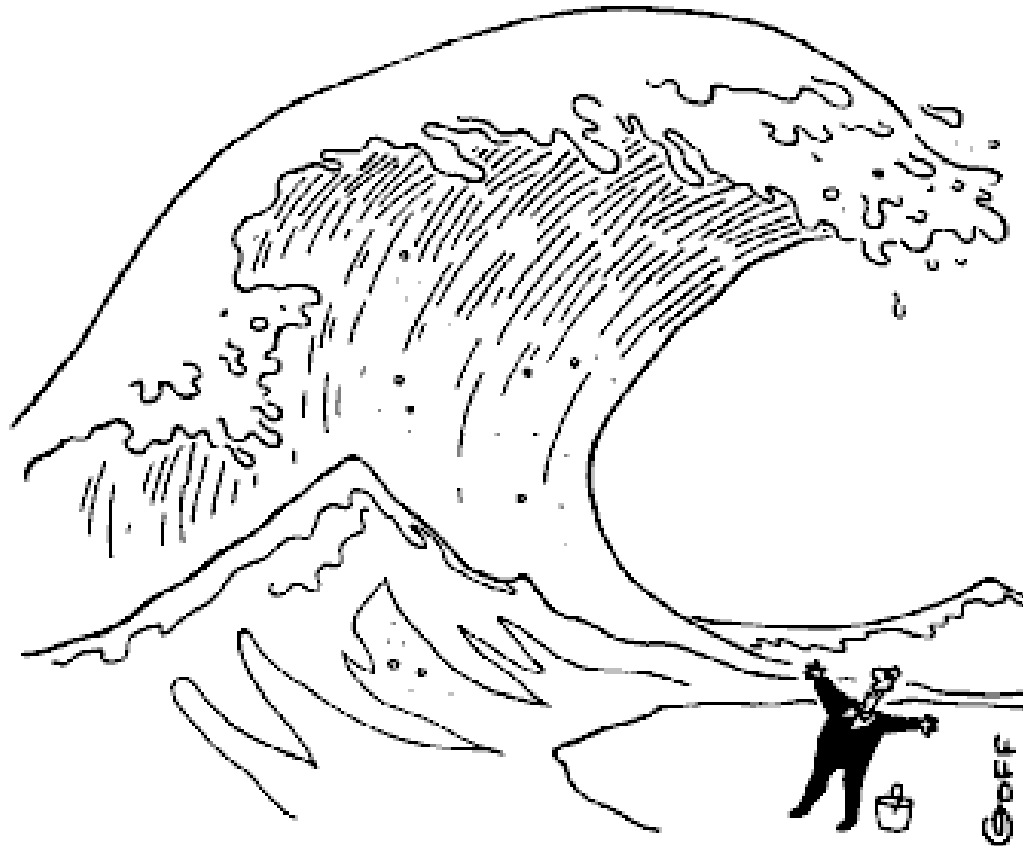
Next Challenge

Improved Analytical Tools

Legal/Cultural Issues

As we begin to get over the first hurdle, we must start working on the next one . . .

Information Overload

©1996 Ted Goff

"EUREKA! MORE INFORMATION!"

From Data to Information

Tools and processes to convert large quantities of data into useful information

Data Sources

Info from front line staff and other sources

DATA

Analysts

USEFUL

INFORMATION

Tools

Processes

Smart Decisions

- **Identify issues**
- *PRIORITIZE!!!*
- **Develop solutions**
- **Evaluate interventions**

Aviation Success Story

65% Decrease in Fatal Accident Rate, 1997 - 2007

largely because of
System Think

fueled by
Proactive Safety Information Programs

P.S. Aviation was already considered *VERY SAFE* in 1997!!

Aviation "System Think" Success

- **Engage _All_ Participants In Identifying Problems and Developing and Evaluating Remedies**

- **Airlines**

- **Manufacturers**
  - *With the systemwide effort*
  - *With their own end users*

- **Air Traffic Organizations**

- **Labor**
  - *Pilots*
  - *Mechanics*
  - *Air traffic controllers*

- **Regulator(s)** [Query: Investigator(s)?]

AIRLINES

PILOTS   CONTROLLERS

The System

MECHANICS   MANUFACTURERS

INVESTIGATOR
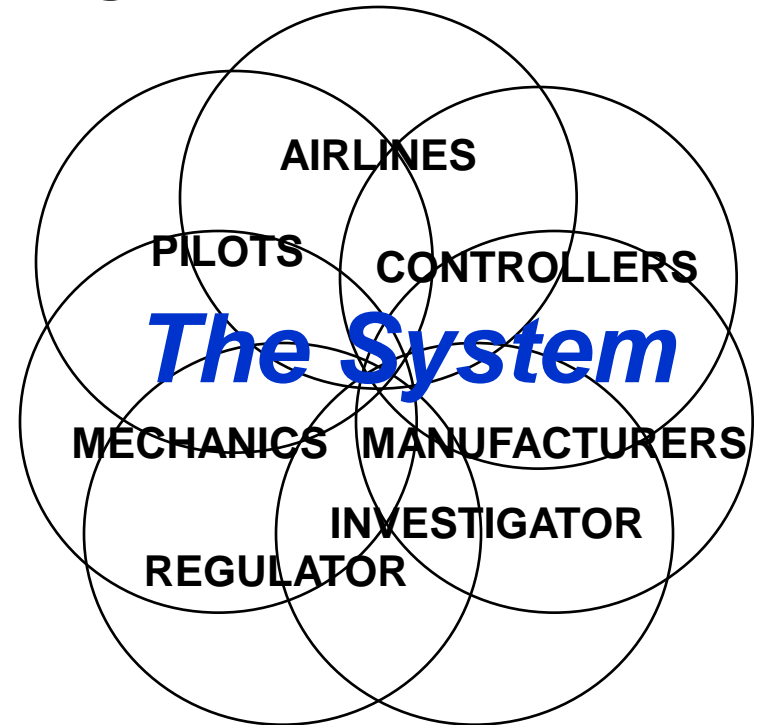
REGULATOR

Collaboration: A Major Paradigm Shift

– **Old: Regulator identifies a problem and proposes solutions**
  - **Industry skeptical of regulator's understanding of the problem**
  - **Industry resists regulator's solutions and/or implements them begrudgingly**

– **New: Collaborative "System Think"**
  - **Industry involved in identifying problem**
  - **Industry has "ownership interest" re solution because everyone had input, everyone's interests considered and better understood by all**
  - **Prompt and willing implementation (and tweaking)**
  - **Solution probably more effective and efficient**
  - **Unintended consequences much less likely**

Challenges of Collaboration

- Human nature: "I'm doing great . . . *the problem is everyone else*"

- Differing and sometimes competing interests
  - Labor-management issues between participants
  - Participants are potential adversaries

- Regulator probably not welcome

- Not a democracy
  - Regulator must regulate

- Requires all to be willing, in their *enlightened self-interest,* to leave their "comfort zone" and think of the System

Manufacturer "System Think" Success

Aircraft Manufacturers are Increasingly Seeking Input, Throughout the Design Process, From

- Pilots　　　　　　　　(*User* Friendly)

- Mechanics　　　(*Maintenance* Friendly)

- Air Traffic Services　(*System* Friendly)

Moral of the Story

- **"System Think" can be successful at any macro/micro level, including**

    - **Entire industry**

    - **Company (some or all)**

    - **Type of activity**

    - **Facility**

    - **Team**

Failure: Inadequate "System Think"

- **1995 – Cali, Colombia**
- **Risk Factors**
  - *Night*
  - *Airport in Deep Valley*
  - *No Ground Radar*
  - *Airborne Terrain Alerting Limited to "Look-Down"*
  - *Last Minute Change in Approach*
    - ➢ *More rapid descent (throttles idle, spoilers)*
    - ➢ *Hurried reprogramming*
- **Navigation Radio Ambiguity**
- **Spoilers Do Not Retract With Power**

Recommended Remedies Include:

- **Operational**
  - *Caution Re Last Minute Changes to the Approach*

- **Aircraft/Avionics**
  - **Enhanced Ground Proximity Warning System**
  - **Spoilers That Retract With Max Power**
  - **Require Confirmation of Non-Obvious Changes**
  - **Unused or Passed Waypoints Remain In View**

- **Infrastructure**
  - **Three-Letter Navigational Radio Identifiers**
  - **Ground-Based Radar**
  - **Improved Reporting of, and Acting Upon, Safety Issues**

Note: All but one of these eight remedies address system issues

Major Benefit: $avings*

Significantly More
**Than Savings From
Mishaps Prevented**
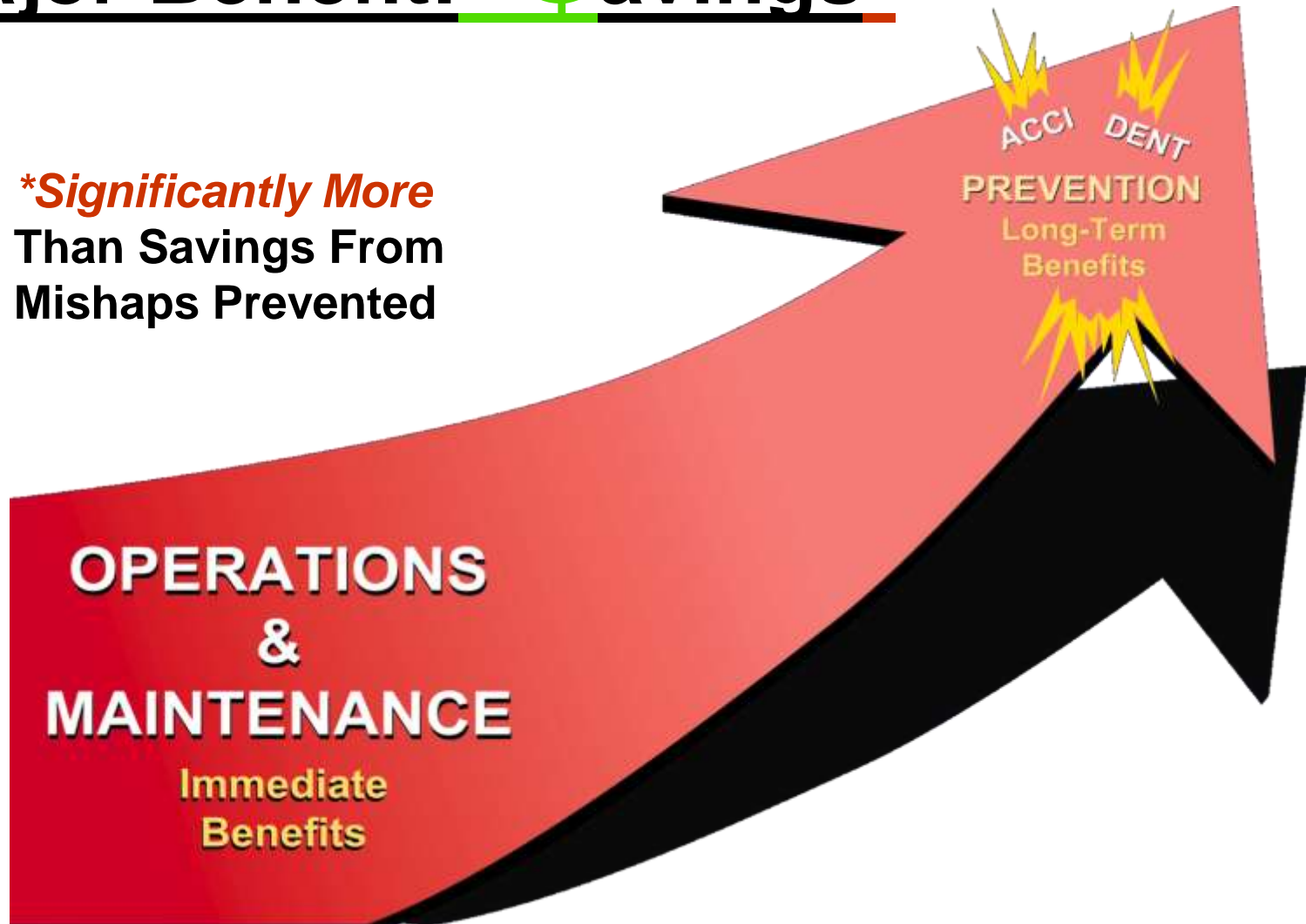
Not Only Improved Safety,
But Improved Productivity, Too

- **Ground Proximity Warning System**
  - *S: Reduced warning system complacency*
  - *P: Reduced unnecessary missed approaches, saved workload, time, and fuel*

- **Flap Overspeed**
  - *S: No more potentially compromised airplanes*
  - *P: Significantly reduced need to take airplanes off line for VERY EXPENSIVE (!!) disassembly, inspection, repair, and reassembly*

But Then . . .

Why Are We

So Jaded in The Belief That

Improving Safety

Will Probably

Hurt The Bottom Line??

Costly Result$
Of Safety Improvements Poorly Done

Safety *Poorly* Done

1. **Punish/re-train operator**

- Poor workforce morale

- Poor labor-management relations

- Labor reluctant to tell management what's wrong

- Retraining/learning curve of new employee if "perpetrator" moved/fired

- Adverse impacts of equipment design ignored, problem may recur because manufacturers are not involved in improvement process

- Adverse impacts of procedures ignored, problem may recur because procedure originators (management and/or regulator) are not involved in improvement process

Safety *Well* Done

Look beyond operator, also consider system issues

Costly Result$
Of Safety Poorly Done (con't)

Safety _Poorly_ Done

Safety _Well_ Done

2. Management decides remedies unilaterally

- Problem may not be fixed

- Remedy may not be most effective, may generate other problems

- Remedy may not be most cost effective, may reduce productivity

- Reluctance to develop/implement remedies due to past remedy failures

- Remedies less likely to address multiple problems

Apply "System Think," _with workers_, to identify and solve problems

3. Remedies based upon instinct, gut feeling

- Same costly results as No. 2, above

Remedies based upon evidence (including info from front-line workers)

Costly Result$
Of Safety Poorly Done (con't)

Safety *Poorly* Done

Safety *Well* Done

**4. Implementation is
   last step**

**Evaluation after
implementation**

 - *No measure of how well remedy worked (until next mishap)*

 - *No measure of unintended consequences (until something
   else goes wrong)*

Query: Is Safety Good Business*?*

- *Safety implemented poorly can be very costly (and ineffective)*

 - *Safety implemented well, in addition to improving safety more
   effectively, can also create benefits greater than the costs*

The Role of Leadership

- Demonstrate Safety Commitment . . .
But Acknowledge That Mistakes Will Happen
- Include "Us" (*e.g.*, System) Issues,

Not Just "You" (*e.g.*, Training) Issues
- **Make Safety a Middle Management Metric**
- Engage Labor Early
- Include the *System* --
Manufacturers, Operators, Regulator(s), and Others

- Encourage and Facilitate Reporting
- Provide *Feedback*
- Provide Adequate *Resources*
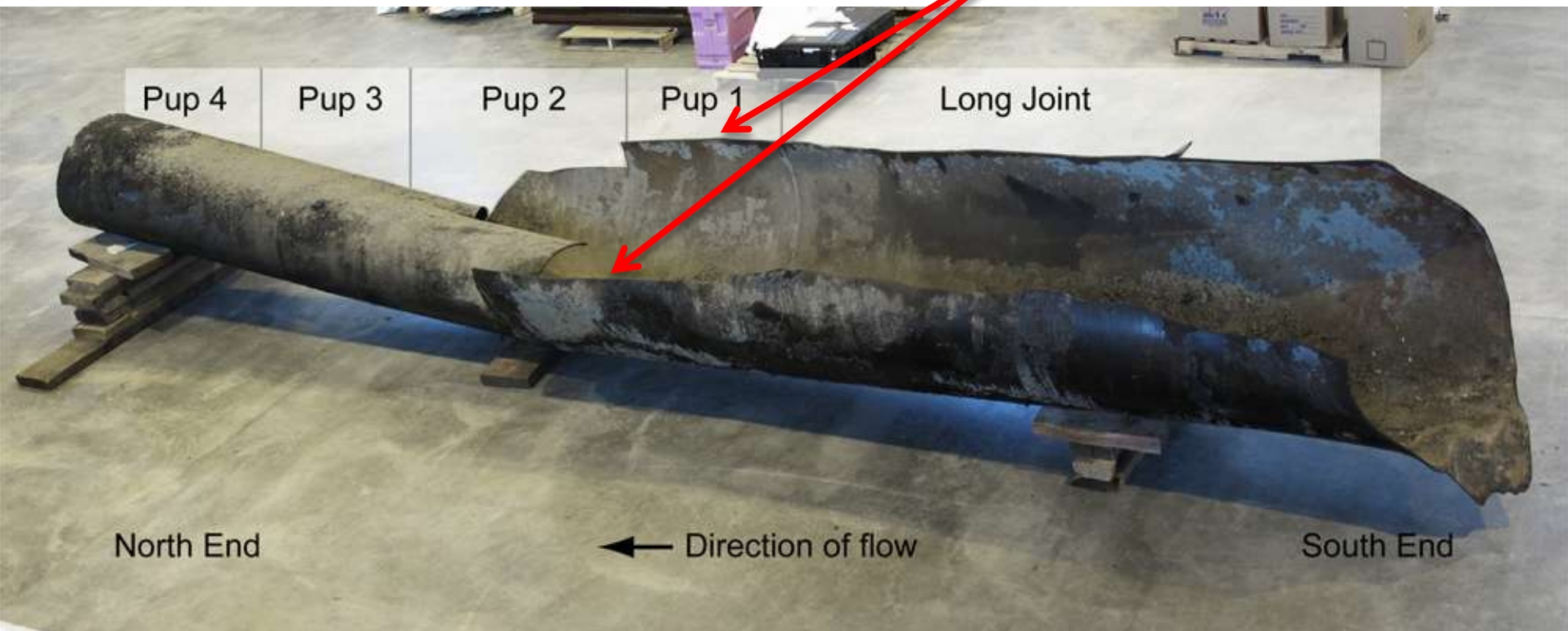- *Follow Through* With Action

How The Regulator Can Help

- Emphasize importance of System issues
in addition to (*not instead of*) worker issues

- Encourage and participate in

industry-wide "System Think"

- Facilitate collection and analysis of information
  • Clarify and announce *policies for protecting*

  information and those who provide it

  • Encourage other industry participants
  to do the same

- Recognize that *compliance* is very important,
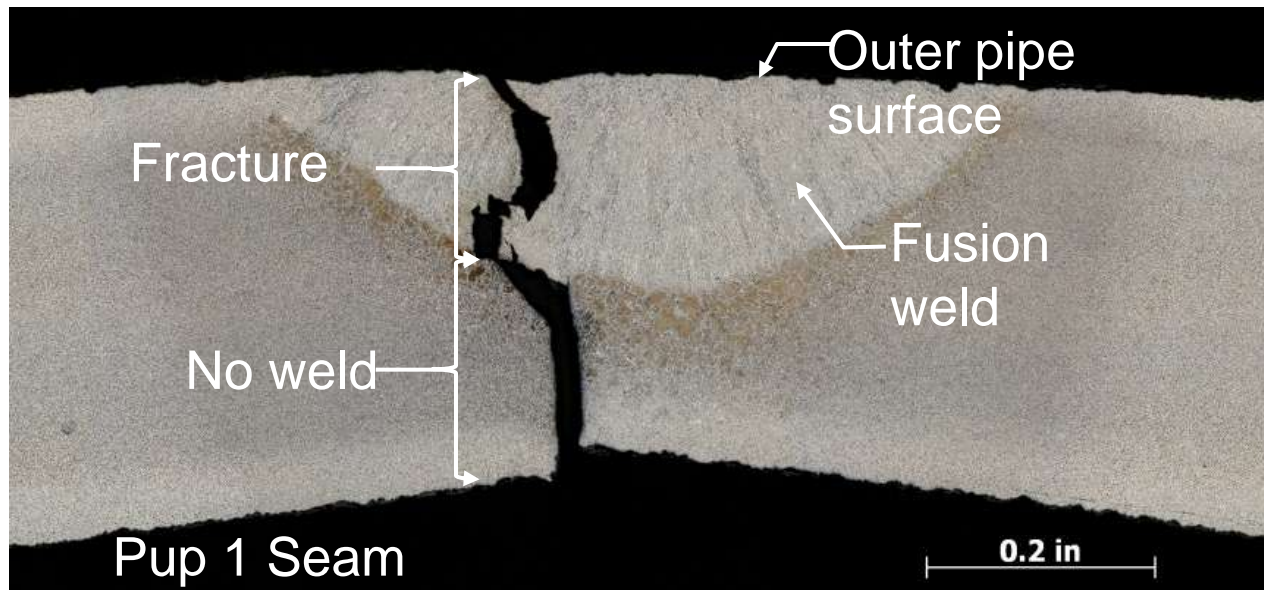but the *mission is reducing systemic risk*
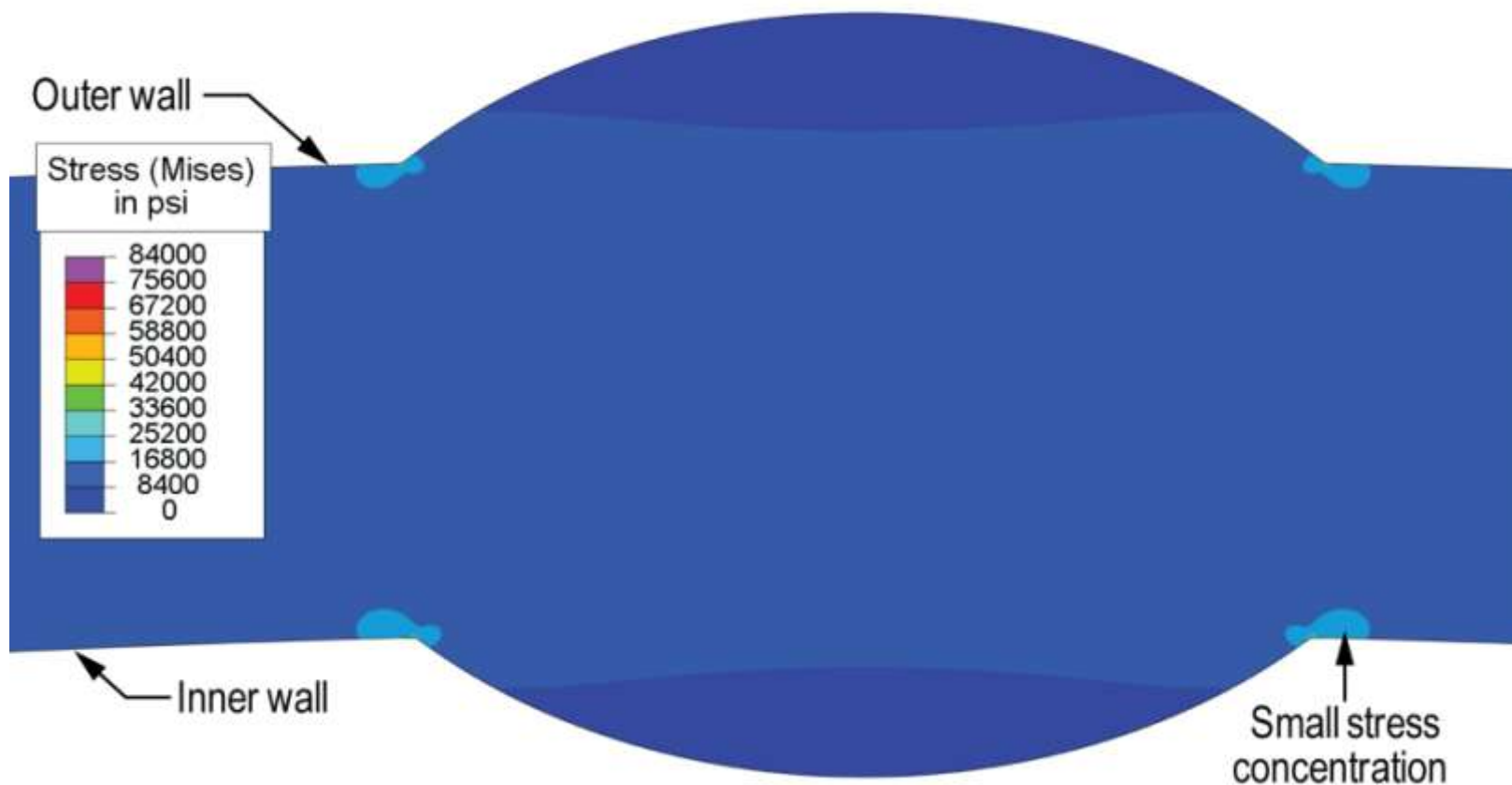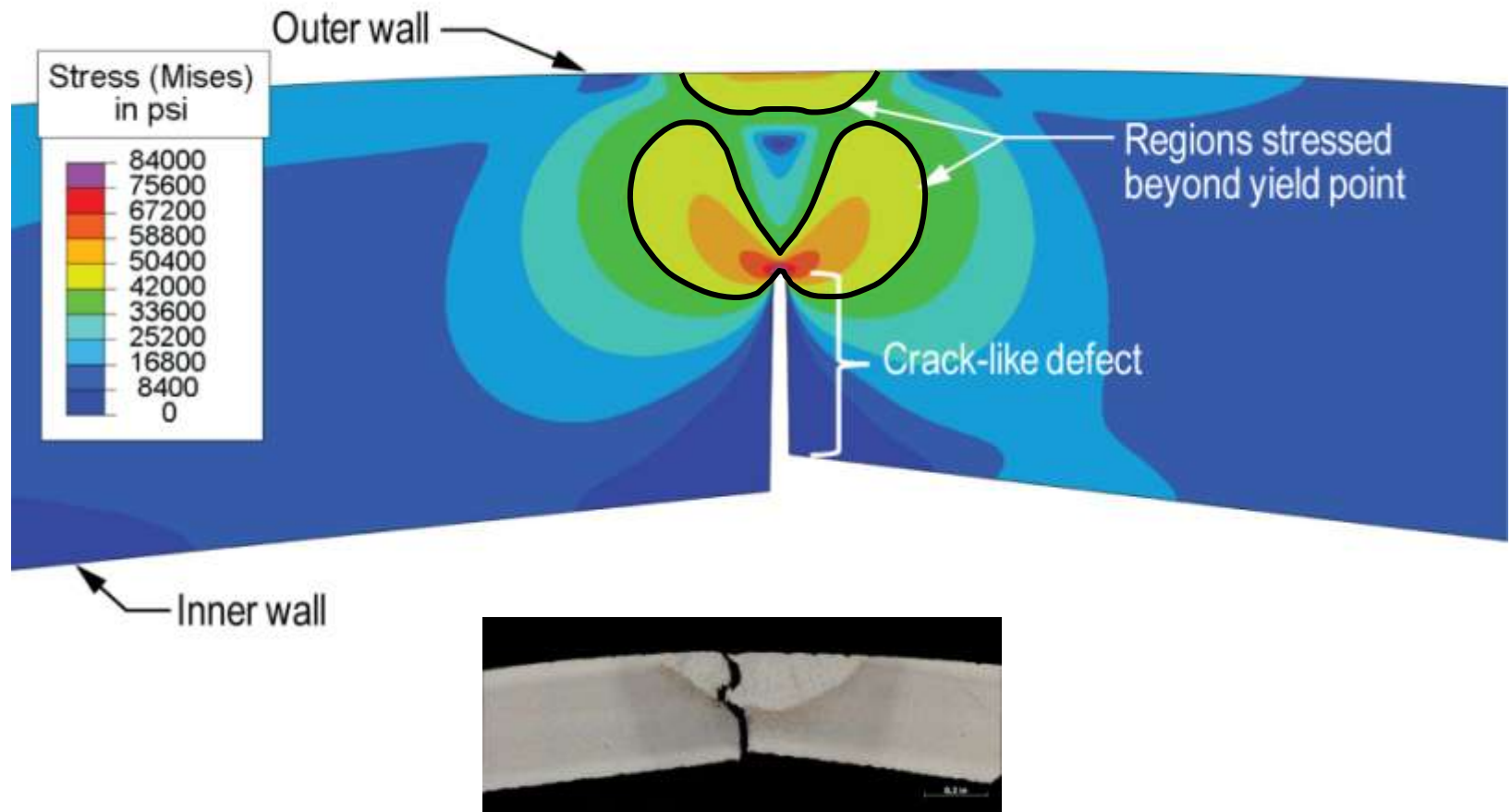
San Bruno: Separated Pipe Segment

Cross Section of Pipe Welds

Pup 1 Seam — Fracture, No weld, Outer pipe surface, Fusion weld, 0.2 in

DSAW Seam — 0.2 in

Stresses at DSAW Weld

Stresses at Incomplete Weld

Probable Cause

- **Inadequate QA/QC during construction**

- **Inadequate integrity management**

- **Contributing to accident:**

  - **Grandfathering re pressure testing**

  - **Inadequate oversight by regulators**

- **Contributing to severity:**

  - **Lack of automatic shutoff or remote control valves**

  - **Inadequate emergency response**

Major Recommendation Areas:

- Delete grandfather clause and require hydrostatic testing at 1.25 MAOP for older pipelines to be declared stable

- Revise integrity management inspection protocols to minimize threat of pipeline ruptures

- Require installation of automatic shutoff or remote-control shutoff valves in high consequence areas

- Audits of safety oversight process

- Provide system-specific information about pipeline systems to emergency response agencies

Thank You!!!

Questions?